



## Prior Authorization Criteria for Inhaled Corticosteroids/Long-Acting Beta Agonists (ICS/LABAs) Combinations

### Background

The inhaled corticosteroids/long-acting beta agonists (ICS/LABAs) combinations include fluticasone/salmeterol (Advair Diskus or HFA), budesonide/formoterol (Symbicort), mometasone/formoterol (Dulera), and fluticasone/vilanterol (Breo Ellipta). These drugs are used in the treatment of asthma and/or maintenance treatment of airflow obstruction and reducing exacerbations in patients with chronic obstructive pulmonary disease (COPD).

### What is Step Therapy?

Step therapy involves prescribing a safe, cost effective medication as the first step in treating a medical condition. The preferred medication is often a generic medication that offers the best overall value in terms of safety, effectiveness, and cost. Non-preferred drugs are only prescribed if the generic is ineffective or poorly tolerated. **Symbicort, Dulera, and Breo Ellipta** will only be approved for current and new users after they have satisfied the requirements to try the preferred ICS/LABA on the Department of Defense (DoD) Uniform Formulary AND the clinical requirements listed below.

#### Prior Authorization Criteria for Symbicort, Dulera, and Breo Ellipta

Coverage for **Symbicort, Dulera, or Breo Ellipta** is approved if current and new patients older than 12 years of age meet the following criteria:

**Automated PA Criteria:** The patient has filled a prescription for Advair Diskus or Advair HFA at any MHS pharmacy POS [Military Treatment Facilities (MTFs), retail network pharmacies, or mail order] during the previous 180 days.

AND

**Manual PA Criteria, if automated criteria are not met:** **Symbicort, Dulera, or Breo Ellipta** is approved (e.g., a trial of Advair Diskus or Advair HFA is NOT required) if:

- Patient has experienced any of the following issues with either Advair Diskus or Advair HFA, which is not expected to occur with non-preferred ICS/LABA combination drug:
  - Inadequate response to Advair Diskus or Advair HFA
  - Intolerable adverse effects
  - Contraindication
  - Patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk

*Criteria approved through the DOD P&T Committee process February 2014*

Prior Authorization Request Form for  
budesonide/formoterol (**Symbicort**) – fluticasone/vilanterol (**Breo Ellipta**) –  
mometasone/formoterol (**Dulera**)



6041

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER  
and  
RETAIL

- The provider may **call: 1-866-684-4488**  
or the completed form may be **faxed to:**  
**1-866-684-4477**

- The patient may attach the completed form  
to the prescription and **mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**  
or **email** the form only to:  
**TpharmPA@express-scripts.com**

Prior authorization criteria and a copy of this form are available at: [http://pec.ha.osd.mil/forms\\_criteria.php](http://pec.ha.osd.mil/forms_criteria.php). This prior authorization has no expiration date.

**Note: PA criteria do not apply to children younger than 12 years.**

**Step 1** Please complete patient and physician information (please print):

Patient Name: \_\_\_\_\_ Physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Sponsor ID # \_\_\_\_\_ Phone #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Secure Fax #: \_\_\_\_\_

**Step 2** Please complete the clinical assessment:

1. Is the use of Advair Diskus (fluticasone/salmeterol) or Advair HFA contraindicated?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 2
2. Has the patient experienced intolerable adverse effects to Advair Diskus or Advair HFA?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 3
3. Has the patient had an inadequate response to Advair Diskus or Advair HFA?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 4
4. Has the patient previously responded to the nonformulary agent and changing to Advair Diskus or Advair HFA would incur unacceptable risk?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

Date

[ 9 July 2014 ]